MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-rd)

CERTIFICATE OF DEATH

★ 10259 230 Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Pr. Geo. Co
City or town Beltsville (If outside city or town limits, write RURAL and give nearest town) md
How long in above place of death? 20 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Pr. Geo
City or town Berwyn (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Matilda J. Allen

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife Elmer F. Allen
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Dec 15 1881

8. AGE: Years	Months	Days	If less than one day
63			..... hrs. ..... min.

9. Birthplace Montgomery Co Md (Town, county, and state)
10. Usual occupation U.S. Gov. Bureau
11. Industry or business

FATHER	12. Name	James Carlin
	13. Birthplace	W. Virginia
MOTHER	14. Maiden name	Matilda Tasney
	15. Birthplace	W. Virginia

16. Informant James C. Allen
Address Berwyn. Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/19/45 (month) (day) (year)
Cemetery or crematory Ft. Lincoln
Location ~~Wash. D.C.~~ Bladensburg Md
18. Funeral director W. W. Chandlee Co.
Address Riverdale, md
19. 10/19 1945 Amanda Downey Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1945 at 6:15 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1943 to Oct 17 1945
and that I last saw her alive on Oct 17 1945

Immediate cause of death	DURATION
(a) Chronic myocarditis	3 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Robt T. Gormley M.D. M. D. or other
Address 40 W Main St Laurel Md Date signed 10/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1467)

CERTIFICATE OF DEATH

10260

★ Reg. Dist. No. 231

1. PLACE OF DEATH:

County: Prince George

City or town: Cheverly, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Prince George Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Glenarden (Silesia)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 8352 Livingston Road S.E.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Baughan Mrs. Catherine

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Baughan Mr. Samuel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 24, 1910

8. AGE: Years	Months	Days	If less than one day
35	Apr.	24	..... hrs. ..... min.
1910			

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business

FATHER — 12. Name: Alexander Maley

13. Birthplace: Canada

MOTHER — 14. Maiden name: Mary Gwyn

15. Birthplace: Va.

16. Informant: Baughan Mr. Samuel Husband

Address: 8352 Livingston Rd, Silesia

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 23, 1945 (month) (day) (year) Md.

Cemetery or crematory: Fort Lincoln

Location: Colmar Manor Md

18. Funeral director: L. Gaudie Sons

Address: Hyattsville Md.

19. 10/22/45 (Date rec'd by registrar) Amanda Deuney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 21 1945 at 2:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3-4-45 1945 to 10-21 1945 and that I last saw h.er alive on 10-21-45 1945

Immediate cause of death	DURATION
Post Partum hemorrhage	1 hr
Due to: Uterus cervical laceration	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John P. Clum M.D. M. D. or other

Address: Hyattsville Md Date signed: 10-21-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 10261243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mos., 7 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 7 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 16 - E. St. S. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: CHESTER LAWRENCE BEAL

3.(b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Elaine Beal
6.(c) If alive, give age: 20 years

7. Birth date of deceased (mo., day, yr.): April 28, 1918

8. AGE: Years	Months	Days	If less than one day
27	6	-	...hrs. ...min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business:
FATHER — 12. Name: John W. Beal
13. Birthplace: Oxon Hill, Maryland
MOTHER — 14. Maiden name: Nellie Dorsey
15. Birthplace: Washington, D. C.
16. Informant: Decedent
Address:
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 29, 1945 (month) (day) (year)
Cemetery or crematory: Washington,
Location: D. C.
18. Funeral director: Robert G. Mason
Address: 2500 Nichols Ave S.E.
19. Oct. 25 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 28th 1945, at 4:55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21st 1945 to Oct 28th 1945 and that I last saw him alive on October 28th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	11 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 10/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48)

CERTIFICATE OF DEATH

10262

Reg. Diat. No. 242

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Woods Corner, Washington 20 DC
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred:
Woods Corner Branch Ave S.E.
How long in hospital or institution? — none —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Georges
City or town: Rural - Woods Corner
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Washington 20 DC
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Mary Booze

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	negro	widowed

6.(b) Name of husband or wife: John Booze (uncle Jack)
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): — unknown 1875-

8. AGE: Years	Months	Days	If less than one day
70 unknown	8 mnths	1	hrs. min.

9. Birthplace: Prince Georges Co. Md
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: — Farm —
12. FATHER — Name: unknown
13. Birthplace: —
14. MOTHER — Maiden name: Matilda Curtain
15. Birthplace: unknown
16. Informant: Susie Odom
Address: 10 J H Washington 20 DC
17. Burial (Burial, cremation, or removal. Which?) Date thereof 01-28-1945- (month) (day) (year)
Cemetery or crematory: L-B-md-
Location: Brookmont md
18. Funeral director: Robert J. Mason
Address: 2501 Nichols Ave. S.E.
19. 01-23-1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 23 1945, at 8 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1. 1941 to Oct 23 1945
and that I last saw h[illegible] alive on Oct 20 1945

	DURATION
Immediate cause of death: acute cardiac failure	2 hrs
Due to: Carcinoma of uterus - Rodent ulcer of	1 yr
Due to: Nose - secondary	2 yr
Other conditions: Cardiovascular	one year
Renal Disease	indefinite

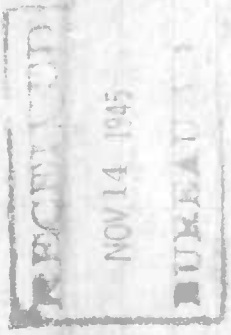
(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: no Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: none Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Washington 19 DC Date signed: 10/23/45

Permission from Dr James J Boyd to
request certificate granted by
telephone message today Oct 25 1945.
Jane E Sanderlin



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

16263

CERTIFICATE OF DEATH

Reg. Dist. No. 273

1. PLACE OF DEATH:
County: Prince George's
City or town: Mar Collington
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Pr. George's
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: No

3. (a) FULL NAME: George W. Brown

3. (b) Social Security Number: 579-14-8919

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Married

6 (b) Name of husband or wife: Belita Brown
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 30, 1874

8. AGE:

Years	Months	Days	If less than one day
71	-	-	hrs. min.

9. Birthplace: Pr. Geo. Co.
(Town, county, and state)

10. Usual occupation:
11. Industry or business: Machinist Helper

FATHER
12. Name: Richard Brown
13. Birthplace: Md

MOTHER
14. Maiden name: Higgs
15. Birthplace: Md

16. Informant: Belita Brown
Address: near Collington

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-9-45 (month) (day) (year)
Cemetery or crematory: Ascension
Location: Bowie Md

18. Funeral director: Martin Flowers Sons
Address: Bowie Md

19. October 8 1945 (Date rec'd by registrar) Mrs. J. W. Yingling (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 5 1945, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4 1945 to Oct 5 1945, and that I last saw [illegible] alive on Oct 5 1945.

Immediate cause of death	DURATION
(a) Chronic Myocarditis	5 Yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert T. McCreary M.D. M.D. or other
Address: Laurel Md Date signed 10/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11 oc)

CERTIFICATE OF DEATH

10264

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges

City or town Suitland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Permanent

Hospital, institution, or street address where death occurred:

Suitland Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 338-13th St N.E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Grace Virginia Bushong

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William Bushong

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 7, 1916

8. AGE: Years 29 | Months 3 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace District of Columbia (Town, county and state)

10. Usual occupation Beauty Operator

11. Industry or business

FATHER 12. Name Harold A. Steinmeier

13. Birthplace D. C.

MOTHER 14. Maiden name Mary A. Gravenstein

15. Birthplace Baltimore, Md

16. Informant Doris Mae Campbell

Address 142 - 3rd St N.E., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-24-45 (month) (day) (year)

Cemetery or crematory Arlington Cemetery

Location Arlington, Va.

18. Funeral director C. B. Chamberlain

Address 5717 H St N.E.

19. 10/22 19 45 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 19 45, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to Compound fracture of Tibia	
Due to Fracture of base of skull	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 10-21-45

Where did injury occur? Suitland (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Suitland Road

Manner of injury Injured while pedestrian struck by car

23. SIGNATURE Deputy Medical Examiner M. D. or other

Address Forestville Md. Date signed 10-21-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (34)

CERTIFICATE OF DEATH

10265

★ Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George 's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 3 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 3 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 518 - 4th St. S. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: GEORGE. BUTLER,

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married (separated)

6.(b) Name of husband or wife: Clara Butler
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): July 29, 1907

8. AGE: Years	Months	Days	If less than one day
38	2	3	....hrs. ....min.

9. Birthplace: Richmond, Virginia
(Town, county, and state)
10. Usual occupation: Painter
11. Industry or business:

FATHER
12. Name: George Butler
13. Birthplace: St. Louis, Mo.

MOTHER
14. Maiden name: Lillian Coates
15. Birthplace: Richmond, Virginia

16. Informant: Decadent
Address:

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Oct. 3 1945 (month) (day) (year)
Cemetery or crematory:
Location: to Washington D.C.
18. Funeral director: John T. Phillips & Co
Address: 901 - 3rd. St. S.W.

19. Oct. 2, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 2nd 1945, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29th 1945 to Oct 2nd 1945 and that I last saw h[illegible]ive on Oct 2nd 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 10/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-1)

CERTIFICATE OF DEATH

10265

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Pr. Geo. Co.
City or town: Colmar Manor, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Pr. Geo.
City or town: Colmar Manor
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4231 Bladensburg Rd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lewis Carter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mary W. Carter
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 9 1882

8. AGE: Years: 62 Months: Days: If less than one day: hrs. min.

9. Birthplace: Va (Town, county, and state)
10. Usual occupation: Retired Marine Engineer
11. Industry or business:

FATHER
12. Name: Samuel T. Carter
13. Birthplace: Va

MOTHER
14. Maiden name: Mary W. Groves
15. Birthplace: Va.

16. Informant: Mary W. Carter
Address: Colmar Manor, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-20-45 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: Md. Rt. 1
18. Funeral director: W W Chambers Co
Address: Riverdale, Md

19. 10/19 1945 (Date rec'd by registrar) Amanda Denney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/17 1945 at 3 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1, 1945, to Oct 17 1945 and that I last saw h.. alive on Oct 17 1945

Immediate cause of death	DURATION
Carcinoma Left Lung	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: S/ Stargeon M. D. or other
Address: 3717-38th Ave Date signed: 10/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

CERTIFICATE OF DEATH

10267

★ Reg. Dist. No. 342

1. PLACE OF DEATH:
County: Prince Georges
City or town: Hillside – Washington 19 DC
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred: 1306 – 57th ave Capital Heights Md.
How long in hospital or Institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr. Georges
City or town: Capital Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1306 – 57 Ave Capital Heights Md
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Ida May Margaret Cash

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	W	married

6.(b) Name of husband or wife: Edward P. Cash
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Aug. 22 1863

8. AGE: Years: 81 | Months: — | Days: — | If less than one day: ..... hrs. ..... min.

9. Birthplace: Alexandria Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at home

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: Mary Dudley
15. Birthplace: unknown

16. Informant: Edward P Cash
Address: 1306 – 57th Ave Capital Heights Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-16-45 (month) (day) (year)
Cemetery or crematory: Prospect Hill
Location: Wash. DC

18. Funeral director: W. W. Chambers Co.
Address: 517 11th St S.E.

19. Oct 15 1945 (Date rec'd by registrar) Irene A. Conner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 14 1945 at 1A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4 1945 to Oct 14 1945 and that I last saw h.. alive on Oct 13 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage (Paralysis Right Side)	9 days
Due to: General Arteriosclerosis	Unknown
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Washington 19 DC Date signed: Oct 14 1945

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BO)

CERTIFICATE OF DEATH

10268

★ Reg. Diat. No. 242.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Prince Georges

City or town: Lanham (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one week

Hospital, institution, or street address where death occurred: Defense Highway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Lanham (If outside city or town limits, write RURAL and give nearest town)

Street No.: Defense Highway (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Josephine Agnes Chalfonte

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Lester F. Chalfont

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): January 16, 1883

8. AGE: Years: 62 | Months: 9 | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace: New York City, N. Y. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER — 12. Name: Cornelius Donoghue

FATHER — 13. Birthplace: Ireland

MOTHER — 14. Maiden name: Ann Watson

MOTHER — 15. Birthplace: Ireland

16. Informant: Reginald Chalfonte

Address: Lanham, Md

17. Transportation (Burial, cremation, or removal, Which?) Date thereof: Oct. (month) 19 (day) 1945 (year)

Cemetery or crematory: Gadron Nebraska

Location: Gadron Nebraska

18. Funeral director: J. Gude's sons

Address: Hyattsville Md

19. 10/19/45 (Date rec'd by registrar) Amanda Downey (Registrar)

Mrs J Bennett D. L. Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 18 1945 at 6.25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute Congestive heart failure	
Due to: Cardio vascular renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Deputy medical examiner Joshua J. Ford M. D. or other

Address: Forestville Md Date signed 10-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

10269

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince George
City or town: Riverdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 63 days
Hospital, Institution, or street address where death occurred:
Leland Memorial Hospital
How long in hospital or institution? 63 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James A. Clampet.

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Mary Jane Clampet
6.(c) If alive, give age: no years
7. Birth date of deceased (mo., day, yr.): Jan 15, 1872.
8. AGE: Years 73 44 | Months 7 | Days 23 | If less than one day: hrs. min.
9. Birthplace: Rowan County No. Carolina (Town, county, and state)
10. Usual occupation: Jeweler
11. Industry or business: Jeweler

FATHER
12. Name: John Clampet
13. Birthplace: Rowan County, N.C.

MOTHER
14. Maiden name: Nancy Nash
15. Birthplace: Rowan County, N.C.

16. Informant: James A. Clampet (Son)
Address: Star Route, Box 10, Laurel, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/10/45 (month) (day) (year)
Cemetery or crematory
Location: Near Poplar, N. Car
18. Funeral director: Wm Wellmeier Co
Address: Riverdale Md

19. Oct 9 1945 (Date rec'd by registrar) James Seavey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 8, 1945, at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Bronchopneumonia,	1 wk.
Due to: Perforated Peptic ulcer (Gastric) exploration	aug. 7-45
Due to:	
Other conditions: Purulent Cholecystitis & Cholelithiasis	?

(Include pregnancy within 3 months of death)

Major findings of operation: as above. Date of op.
Autopsy results: as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Herman D. Slade, M. D. ~~or other~~
Address: Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (119-a)

10270

CERTIFICATE OF DEATH ★

Reg. Dist. No. 232

1. PLACE OF DEATH:
County: PRINCE George
City or town: Upper Marlboro, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Upper Marlboro Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: William Thomas Davis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	S

6.(b) Name of husband or wife: —

7. Birth date of deceased (mo., day, yr.): ~~June~~ May 27, 1945

6.(c) If alive, give age ..... years

8. AGE: Years | Months: 5 | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Upper Marlboro, Maryland (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER — 12. Name: CHARLES DAVIS
13. Birthplace: Anne Arundel Co, Maryland

MOTHER — 14. Maiden name: IDA MARGARET JACKSON
15. Birthplace: Upper Marlboro, Md.

16. Informant: Thomas Jackson
Address: Upper Marlboro, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-11-45 (month) (day) (year)
Cemetery or crematory: Mt. Carmel
Location: Upper Marlboro, Md.

18. Funeral director: Tibbie Bros.
Address: Upper Marlboro, Md.

19. Oct 11 1945 (Date rec'd by registrar) R. E. Hall Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 1945, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 7 1945, to Oct — 19.....
and that I last saw him alive on Oct 7, 1945 19.....

Immediate cause of death	DURATION
Cholera infantum	4 days
Due to: —	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operation: —
Date of op. —
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Reuel Davies M. D. or other
Address: Upper Marlboro, Md. Date signed Oct 10, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10271

Reg. Diat. No. 245

1. PLACE OF DEATH:

County Prince Georges County

City or town Riverdale, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hrs 3 min.

Hospital, Institution, or street address where death occurred:
Eugene Leland Memorial Hosp.

How long in hospital or institution? 6 hrs 3 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D.C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6206 Brooks Rd, S.E.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Henry Edwin Dennison

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife Mary A. Dennison

6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) April 4, 1869

8. AGE: Years	Months	Days	If less than one day
76	6	8	....hrs. ....min.

9. Birthplace Prince Georges Co., Maryland
(Town, county, and state)

10. Usual occupation retired

11. Industry or business Carpenter

FATHER
12. Name James Dennison
13. Birthplace Maryland

MOTHER
14. Maiden name Harriet Burgess
15. Birthplace Maryland

16. Informant (Daughter) Mrs. Mary Schevett
Address 1921-14th Street S.E. Washington D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct. 12th 1945 (month) (day) (year)

Cemetery or crematory 517-11th St. S.E.

Location Washington D.C.

18. Funeral director W. H. Chambers Co.

Address 517-11th St. S.E.

19. Oct. 12" 1945 (Date rec'd by registrar) M.L. as Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12th 1945 at 12 43 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 11 1945, to Oct 12 1945 and that I last saw h.. alive on Oct 12 1945.

	DURATION
Immediate cause of death Bronchial pneumonia	1 week
Due to	
Due to	
Other conditions Hypostatic congestion with senility	10 years

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. W. Malin M.D.
M. D. or other

Address Riverdale, Md. Date signed 10-12-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

10272

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 hrs.

Hospital, institution, or street address where death occurred:

Eugene Leland Memorial Hospital

How long in hospital or institution? 16 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6213 - 42nd Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Infant Girl Dixon

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): October 13, 1945

8. AGE: Years	Months	Days	If less than one day
			16 hrs. min.

9. Birthplace: Riverdale, Maryland (Town, county, and state)

10. Usual occupation: –

11. Industry or business: –

FATHER — 12. Name: Donald Ralph Dixon

FATHER — 13. Birthplace: Hyattsville, Maryland

MOTHER — 14. Maiden name: Katherine Edith Brown

MOTHER — 15. Birthplace: Washington, D. C.

16. Informant: Hospital records as given by

Address: mother.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 15. 1945 (month) (day) (year)

Cemetery or crematory: Forestville Episcopal Church

Location: Forestville, Md.

18. Funeral director: W. W. Chambers & Son

Address: Riverdale Md.

19. Oct. 14th 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 14, 1945, at 10:30 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 13 1945 to Oct 14 1945 and that I last saw her alive on Oct 14 1945.

	DURATION
Immediate cause of death: prematurity	16 hrs.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. W. Malin M.D. M. D. or other

L. W. Malin, M. D.

Address: 4404 Queensbury Rd. Riverdale, Maryland Date signed: 10-14-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

CERTIFICATE OF DEATH

10273

Reg. Diat. No. 243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George

City or town: Bowie Rural

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 19 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Prince George

City or town: Bowie, Rural Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Barbara Rose Mae Dorsey

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec. 9, 1925

8. AGE:

Years	Months	Days	If less than one day
19	10	5	hrs. min.

9. Birthplace: Bowie, Md (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER

12. Name: John Allen Dorsey

13. Birthplace: Bowie, Md

MOTHER

14. Maiden name: Clara Virginia Patton

15. Birthplace: Bowie, Md.

16. Informant: Mary Dorsey

Address: Bowie

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 17 45 (month) (day) (year)

Cemetery or crematory: Pleasant Grove

Location: nr. Bowie Md

18. Funeral director: Martin Feldmeyer Serv

Address: Bowie Md.

19. Oct 16 1945 (Date rec'd by registrar) Mrs. J. W. Giesling Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 14 1945, at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945 to Oct. 1945, and that I last saw h-- alive on Sept. 22 1945.

	DURATION
Immediate cause of death: Cardiac Dilatation	1 hour
Due to: Bronchial Asthma	10 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Henry S. Stone M. D. M. D. or other

Address: Bowie, Md. Date signed 10-14-45

10274

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-F)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 242

1. PLACE OF DEATH:
County Prince George's
City or town Glenwood Park
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 14 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Glenwood Park Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1125 54th Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Fannie Douglas

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	widowed

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27 1887

8. AGE: Years 58? Months Days If less than one day hrs. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden name unknown
15. Birthplace unknown

16. Informant Maud E. Barnes
Address 32 2d St. NW.

17. Burial (Burial, cremation, or removal, Which?) Date thereof Oct. 20, 1945 (month) (day) (year)
Cemetery or crematory Payne's
Location Washington, D.C.

18. Funeral director Bi Johnson
Address Annapolis,

19. Oct 19 1945 (Date rec'd by registrar) Irene A Commes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1945, at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1944 to Oct 16 1945
and that I last saw h alive on Oct 16, 1945

Immediate cause of death Endocarditis — DURATION
Chronic Nephritis
Due to Rheumatic Fever
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations no
Of autopsy no

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide no Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE W. H. Bruce M.D. M. D. or other
Address 5005 Sherrif Rd. D.C. Date signed 10-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

10275

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 13 days
Hospital, Institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 1 mo., 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County: Washington
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 Naylor Ct. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: EDWARD EASTER

3. (b) Social Security Number: 577-24-9805

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 10, 1912

8. AGE: Years	Months	Days	If less than one day
33	1	7	hrs. min.

9. Birthplace: Greenville, S. Carolina
(Town, county, and state)

10. Usual occupation: Pantryman in Club House

11. Industry or business:

FATHER
12. Name: John Easter
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Lizzie Slapp
15. Birthplace: South Carolina

16. Informant: Decedent
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: 10 - 20 - 45 (month) (day) (year)

Cemetery or crematory: —

Location: Washington D. C.

18. Funeral director: STURGEON FUNERAL HOME

Address: 306 L St N.W. (Ref. Taylor)

19. Oct 17, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 17 1945 at 4.55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 4 1945 to Oct. 17, 1945 and that I last saw h[illegible] alive on Oct. 17, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	14 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: 10/17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: Glenn Dale, Maryland- RURAL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County: Washington, D.C.
City or town: (If outside city or town limits, write RURAL and give nearest town)
Street No.: 785- Fairmount St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: ROWWA FAUST

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	Married

6.(b) Name of husband or wife: Amanda Faust
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): April 4, 1871

8. AGE: Years	Months	Days	If less than one day
74	6	6	...hrs. ...min.

9. Birthplace: Yazoo City, Mississippi (Town, county, and state)
10. Usual occupation: Retired tailor
11. Industry or business: -

FATHER
12. Name: Clarence Faust
13. Birthplace: ? Mississippi

MOTHER
14. Maiden name: ?
15. Birthplace: Raleigh, N. Carolina

16. Informant: Mrs. Katherine Taylor, daughter
Address: same add

17. (Burial, cremation, or removal. Which?) Removal Date thereof (month) (day) (year) 10-10-45
Cemetery or crematory: Lincoln Memorial Cemetery
Location: Suitland, Md. Washington D.C.
18. Funeral director: Thomas Fraser Co
Address: 389- R. I. Ave. N.W.

19. (Date rec'd by registrar) Oct. 10 1945 Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10th 1945 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 10th 1945 to Oct 10th 1945 and that I last saw h.me alive on Oct 10th 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D. M. D. or other
Address: Glenn Dale, Md. Date signed: Oct 10 '45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

10277

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince George
City or town Cheverly Md (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days 5 hrs 10 m
Hospital, institution, or street address where death occurred: Prince Georges Hospital
How long in hospital or institution? 4 days 5 hrs 10 m

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Prince George
City or town Riverdale (If outside city or town limits, write RURAL and give nearest town)
Street No. 4544 WELLS Parkway (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MARY Fitzhugh
3.(b) Social Security Number

4. Sex: female
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Edward T. Fitzhugh
6.(c) If alive, give age 69 years
7. Birth date of deceased (mo., day, yr.): March 12, 1874
8. AGE: Years 71 Months Days If less than one day ... hrs. ... min.
9. Birthplace D.C (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name JOHN J. DALEY
13. Birthplace D.C.
MOTHER 14. Maiden name MARGARET THOMPSON
15. Birthplace DC
16. Informant
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof 10 14 1945 (month) (day) (year)
Cemetery or crematory 475 H. st n.w
Location Washington D.C.
18. Funeral director P. J. Goffell
Address 475- H. St N.W
19. 10/16 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1945, at 8:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10, 1945, to October 14, 1945 and that I last saw her alive on October 14th, 1945

	DURATION
Immediate cause of death: Acute myocardial Infarction c̄ Coronary thrombosis	6 days.
Due to: generalized arteriosclerosis	Sev. months.
Due to	
Other conditions: Asthmatic Bronchitis	Sev. months.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Mt. Rainier, Md. Date signed 10/14/45

I

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

File 10278

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince Geo
City or town: Bladensburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 69 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pri Geo
City or town: Bladensburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 207 46th St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Carrie Estella Galloway

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	~~Single~~ Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 17, 1876

8. AGE: Years	Months	Days	If less than one day
69			hrs. min.

9. Birthplace: Bladensburg, Md (Town, county, and state)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: Joseph Galloway
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rachel Harris
15. Birthplace: Maryland

16. Informant: Irma Prather
Address: 643 Rickford NE

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 29 1945 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: Bladensburg Md

18. Funeral director: F. Gaeth's sons
Address: Hyattsville Md

19. 10/29 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 26 1945, at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 1945, to Oct 25 1945
and that I last saw h...e alive on Oct 25 1945

Immediate cause of death	DURATION
Cerebral hemorrage	10-25-45
Due to Hypertension	1-24-44
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. S. Hudson M.D.
M. D. or other
Address: 509 Rhode Island NW Date signed: 10-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

1027

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Turedo
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, Institution, or street address where death occurred:
Beaver Dam Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State District of Columbia County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1017 - 2nd Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Helen May Griffin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 23, 1926

8. AGE:

Years	Months	Days	If less than one day
19	7	2	..... hrs. ..... min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation At home

11. Industry or business

FATHER
12. Name Charles E. Griffin
13. Birthplace Maryland

MOTHER
14. Maiden name Josephine Fitzgerald
15. Birthplace Maryland

16. Informant Charles E. Griffin
Address 914 - 3rd St NE Washington D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 25. 1945 (month) (day) (year)

Cemetery or crematory Stewart Funeral Home
Location 30 N. st N.E Washington D.C.

18. Funeral director F Gaskins Sons
Address Hyattsville Md

19. 10/25 1945 Amanda Downey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1945, at 4:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage	
Shock	
Due to Crushed chest	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 10-25-45
Where did injury occur? Turedo P.G. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Beaver Dam Road
Means of injury Passenger in car to injured at work Tree
Deputy medical Examiner
23. SIGNATURE ..... M. D. or other
Address Forestville Md Date signed 10-25-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-A)

CERTIFICATE OF DEATH

10289

Reg. Dist. No. 245

1. PLACE OF DEATH:
County: Prince Geo. Co.
City or town: Ky attsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Pr. Geo.
City or town: Ky attsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6904 Oak ridge Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Frances Elizabeth Harman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: James Harvey Harman
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 24 1863

8. AGE: Years: 82 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Jonesville, Va
(Town, county, and state)

10. Usual occupation: Housemother

11. Industry or business:

FATHER
12. Name: John Russell Travis
13. Birthplace: Va.

MOTHER
14. Maiden name: Nancy Matilda Clawson
15. Birthplace: Va

16. Informant: Susan Emalyn Harman
Address: 6904 Oakridge, Kyattsville, md

17. Cr. Trans. (Burial, cremation, or removal. Which?) Date thereof: 10/25/45 (month) (day) (year)

Cemetery or crematory: Zion M.E. Church
Location: Omega, Okla

18. Funeral director: Lee Chambers Co
Address: Riverdale, md

19. Oct 25 1945 James Seivey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24 1945, at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1 1934, to Oct. 24 1945
and that I last saw h.er alive on Oct. 24, 1945

Immediate cause of death	DURATION
Hypostatic pneumonia	6 days
Due to Chronic nephritis	about 2 yrs.
Due to Arterio Sclerosis	3 years
Other conditions Cholecystitis	4 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Ernest T. Sappington M.D.
M. D. or other
Address: 1103-16 Washington D.C. Date signed: 10/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10281

Reg. Diat. No. 243

1. PLACE OF DEATH:
County: Prince Georges
City or town: Glenn Dale, Maryland - RURAL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months - 5 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 9 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3459- Holmead Pl., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: BEAMAN, PERRIN, HARRIS

3.(b) Social Security Number: 237-16-2172

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 18, 1904

8. AGE: Years	Months	Days	If less than one day
41	1	3	hrs. min.

9. Birthplace: Rocky Mountain, N. Carolina
(Town, county, and state)
10. Usual occupation: bookkeeper
11. Industry or business: -

FATHER
12. Name: Oliver B. Harris
13. Birthplace: Henderson, N. Carolina

MOTHER
14. Maiden name: Belle Gulley
15. Birthplace: Raleigh, N. Carolina

16. Informant: decedent
Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: Oct. 22, 1945 (month) (day) (year)
Cemetery or crematory: Rocky Mount, N.C.
Location: ~~Washington D.C.~~

18. Funeral director: Martin F. Hyson Co.
Address: 1300 Nat'l Pr. Mad, DC

19. Oct. 21, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 21st 1945 at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 16th 1945, to Oct 21st 1945.
and that I last saw him alive on Oct 21st 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	23 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 10/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10282

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 231

1. PLACE OF DEATH:
County Prince Georges
City or town Suitland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Permanent
Hospital, institution, or street address where death occurred:
Suitland Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Virginia County
City or town Portsmouth
(If outside city or town limits, write RURAL and give nearest town)
Street No. 155 Colin Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Arthur Thomas Hartman — **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Mildred Hartman
6.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) sept 9, 1912.

8. AGE: Years	Months	Days	If less than one day
33			hrs. min.

9. Birthplace new Jersey. (Town, county, and state)
10. Usual occupation Salesman.
11. Industry or business Plumbing Supplies

FATHER
12. Name Howard Hartman
13. Birthplace Bristol Penna.

MOTHER
14. Maiden name Frances Mc Farland
15. Birthplace Pennsylvania

16. Informant Albert M Steinmaier
Address 123 Deep Creek Blvd, Portsmouth Va
17. transportation (Burial, cremation, or removal. Which?) Date thereof oct 22, 1945 (month) (day) (year)
Cemetery or crematory Portsmouth
Location Va:
18. Funeral director F Gaskins sons
Address Hyattsville Md
19. 10/22 1945 Amanda Downey (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1945, at 6 30 A M

I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and shock	
Due to Crushed chest	
Due to Compound fracture L left leg. Laceration R neck.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 10-21-45
Where did injury occur? Suitland (City or town) P.G. (County) Md. (State)
Injured at home, farm, industry, public place (where?) Suitland Rd.
Means of injury Auto Accident Injured Car & Pole Object
Deputy medical Examiner
23. SIGNATURE ..... M. D. or other
Address Forestville Md Date signed 10-21-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-2)

CERTIFICATE OF DEATH

★ 10283

Reg. Dist. No. 231

1. PLACE OF DEATH:
County Pr. Geo. Co.
City or town Ardmore - md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Dist of Columbia County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 216
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary S. Higgs

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Jan 29 - 1942

8. AGE: Years	Months	Days	If less than one day
3			..... hrs. ..... min.

9. Birthplace Wash. D.C. (Town, county, and state)
10. Usual occupation Infant
11. Industry or business

FATHER
12. Name Warren F. Higgs
13. Birthplace D.C.

MOTHER
14. Maiden name Helen Bass
15. Birthplace D.C.

16. Informant Warren F. Higgs Father
Address Wash - D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/15/45 (month) (day) (year)
Cemetery or crematory Ft. Hill Cemetery
Location Fort Lincoln - Md
16. Funeral director Howe Chambers Co
Address 517 - 11th S.E. D.C.

19. Oct 14 1945 (Date rec'd by registrar) Jas. Deneen M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1945 at 9:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1943, to Oct 12 1945 and that I last saw h[illegible] alive on Oct 1 1945

Immediate cause of death	DURATION
Infantile Cerebral Paralysis	3 yrs
Due to	
Due to	
Other conditions Mental defective	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John J. Maloney M.D.
M. D. or other
Address Cheverly-Hyattsville Date signed Md.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 242 — 11284

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince Georges
City or town: Forestville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred: 5400 3rd Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Forestville (If outside city or town limits, write RURAL and give nearest town)
Street No.: 5400 - 3rd Ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Marie Wilhemina Hogeback
3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Hendrich Hogeback
6.(c) If alive, give age: 44 years
7. Birth date of deceased (mo., day, yr.): March 17, 1904

8. AGE: Years	Months	Days	If less than one day
41	6	29	hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Fredrich Koepke
FATHER 13. Birthplace: germany
MOTHER 14. Maiden name: Lindemann
MOTHER 15. Birthplace: germany
16. Informant: Hendrich Hogeback
Address: 5400 - 3rd Ave, Forestville
17. Burial. (Burial, cremation, or removal. Which?) Date thereof: 10-17-45 (month) (day) (year)
Cemetery or crematory: Mt Olivet
Location: Washington D C
18. Funeral director: W W Chambers Co
Address: 513-11 St SE
19. Oct-17 1945 (Date rec'd by registrar) Thos D Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 16 1945 at 4:00 A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1940, to Oct 16 1945
and that I last saw h-e alive on Oct 15 1945

Immediate cause of death	DURATION
Pneumonia	
Due to: Pulmonary tuberculosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James D Boyd M. D. or other
Address: Forestville Md Date signed: 10-16-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

10285

CERTIFICATE OF DEATH

★ Reg. Dist. No. 237

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Prince George
City or town: Aquasco
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 0

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Prince George
City or town: Aquasco
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Richard Jones

3.(b) Social Security Number

4. Sex: M
5. Color or race: Col
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): 1866
8. AGE: Years: 79 Months: Days: If less than one day: ..... hrs. ..... min.
9. Birthplace: Aquasco Md (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farm
FATHER 12. Name: Peter Jones
FATHER 13. Birthplace: Aquasco
MOTHER 14. Maiden name: Kitty Jones
MOTHER 15. Birthplace: Aquasco
16. Informant
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 10, 1945 (month) (day) (year)
Cemetery or crematory: Emblem John Wesley
Location: Aquasco, Md.
18. Funeral director: Myers & Smith
Address: Waldorf Md.
19. Oct 9th 1945 (Date rec'd by registrar) Mrs Henry B. Contee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/8/45 19 ..... at 1 25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/4/45 19 ..., to 10/8/45 19 ...
and that I last saw h... alive on 10/7/45 19 ...

	DURATION
Immediate cause of death: Hypertension	
Heart Disease	6 mo
Due to: Arterial Hypertension	1 mo
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Daniel L. Gaston M. D. or other
Address: Aquasco Date signed: 10/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

16286

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos., 25 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 4 mos., 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1846 Providence St. N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: KEATING, MAMIE

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: William C. Keating
6.(c) If alive, give age: years

7. Birth data of deceased (mo., day, yr.): October 19, 1886

8. AGE: Years	Months	Days	If less than one day
58	11	14	hrs. min.

9. Birthplace: Charleston, S. Carolina
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: John Mell
13. Birthplace: Charleston, South Carolina

MOTHER
14. Maiden name: Minnie Carstan
15. Birthplace: Charleston, South Carolina

16. Informant: Decedent
Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof 10-3-45 (month) (day) (year)
Cemetery or crematory: Washington, D.C.
Location:

18. Funeral director: Robert G. McGrine
Address: 1820-9th, N.W. Wash, D.C.

19. Oct-3, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 3, 1945, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9, 1945, to Oct. 3, 1945
and that I last saw h... alive on Oct. 3, 1945

Immediate cause of death	DURATION
Tuberculosis pulmonary	6 mos.
Due to:	
Due to:	
Other conditions	

(Including pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other
Address: Glen Dale, Md. Date signed: 10/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

10287

CERTIFICATE OF DEATH

★ Reg. Diat. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince George

City or town: Riverdale (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 min.

Hospital, institution, or street address where death occurred: Leland Memorial Hosp. Riverdale Md

How long in hospital or institution? 10 min.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland D.C. County:

City or town: District of Columbia (If outside city or town limits, write RURAL and give nearest town)

Street No. 1413 Ridge Place S.E., D.C. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Un-named Baby Kinney

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	white	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10-22-45

8. AGE:

Years	Months	Days	If less than one day
10 minutes	Oct.	0	0 hrs. 10 min.

9. Birthplace: Riverdale Prince George, Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER

12. Name: Robert Kinney

13. Birthplace: Hardwick, Vermont

MOTHER

14. Maiden name: Margaret Darling

15. Birthplace: Craftsbury, Vermont

16. Informant: (Next Mother) Mrs. Elizabeth Darling

Address: Craftsbury, Vermont

17. Burial (Burial, cremation, or removal—Which?) Date thereof Oct 25, 1945 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Bladensburg Md

18. Funeral director: F. Gracha sons

Address: Hyattsville Md.

19. Oct 25 1945 James Seery (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-22- 1945 at 9.05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-22 1945 to 10-22- 1945 and that I last saw h.e.y. alive on 10-22- 1945

Immediate cause of death: Prematurity

	DURATION
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: C. L. Pauly, M.D. M. D. or other

Address: 503 Hood Hope Rd S.E. Date signed: 10-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 1428 239

1. PLACE OF DEATH:
County: Prince Georges
City or town: Laurel R F D
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 1/2 Mo.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va County:
City or town: Alexandria
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3311 - Commonwealth ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Sharron Marcy

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 12th 1943

8. AGE: Years	Months	Days	If less than one day
1	11	26	hrs. min.

9. Birthplace: Washington D.C.
(Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Ben H. Marcey
13. Birthplace: Portland, Oregon
MOTHER 14. Maiden name: Dorothy L. Rose
15. Birthplace: Portland, Oregon
16. Informant: Ben H. Marcey
Address: 3311 - Commonwealth ave. Alex Va
17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Oct. 9th 1945. (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery.
Location: Bladensburgh Md.
18. Funeral director: H. H. Chambers Co.
Address: Riverdale, Md.
19. Oct 9 1945 Mr Jason Lacy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 8 1945 at 5-P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1945 to Oct 8 1945
and that I last saw h.. alive on Oct 7 1945

Immediate cause of death	DURATION
Meningitis	
Internal Hydro-	
Cephalus	Life
Due to: Birth Injury	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. M. Warren M.D.
M. D. or other
Address: Laurel Md. Date signed: 10/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

10289

CERTIFICATE OF DEATH

★ Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs., 9 mos., 14 days
Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium
How long in hospital or institution? 7 yrs., 9 mos., 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 741 Girard St. N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: CHARLES H. MARSHALL

3.(b) Social Security Number: 578-03-0534

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Nellie Marshall
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): March 8, 1894

8. AGE: Years	Months	Days	If less than one day
51	6	28	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Breadman – Walter Reed Hosp.
11. Industry or business:

FATHER
12. Name: Singleton H. Marshall
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah E. Marshall
15. Birthplace: Maryland

18. Informant: Decedent
Address:

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: 10-6-45 (month) (day) (year)
Cemetery or crematory: Mt Zion Md
Location: Montgom Co Md
18. Funeral director: Edgar Barlow
Address: Laytonsville md

19. Oct 6 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 6 1945 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 22 1937, to Oct 6 1945 and that I last saw him alive on Oct. 5, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	9 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ...
Means of injury: ... Injured at work?

23. SIGNATURE: Daniel Leo Pinucane M.D. M. D. or other
Address: Glenn Dale Md Date signed: 10/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

10290

Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Pr. Ges Co
City or town: near Bowie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 32 yr
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pr Ges
City or town: near Bowie
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Agnes May Mentz

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): May 1st 1875

8. AGE:

Years	Months	Days	If less than one day
70	5	13	— hrs. — min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Retired School Teacher
11. Industry or business: Bookkeeping
12. Name of FATHER: Thomas V. Mentz
13. Birthplace of FATHER: England
14. Maiden name of MOTHER: Mary E. Upton
15. Birthplace of MOTHER: Maryland
16. Informant: Alice Pollock
Address: near Bowie
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 17 45 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Washington D. C.
18. Funeral director: Martin Flaherty Sons
Address: Bowie Md
19. Oct 15 1945 (Date rec'd by registrar) Mrs. J. N. Yingling Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 14 1945, at 8:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1 1945 to Oct. 14 1945 and that I last saw her alive on Oct. 14 1945

Immediate cause of death: Arterio Sclerotic heart disease — DURATION:
Due to: Coronary Occlusion
Due to: —
Other conditions: —
(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: G E Talcott M.D.
M. D. or other
Address: Bowie Md Date signed Oct 14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

10291

1. PLACE OF DEATH (95-d)

County Prince Georges County Registration Dist. No. 245

Village or City Riverdale No. Leland Memorial Hospital St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residance in city or town where daath occurred ... yrs. ... mos. 5 ds. How long in U.S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Belva L. Midkiff If U. S. Veteran, specify WAR ✓

(a) Residence: No. 11½ 4th St. S.E. Washington D. C. Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Married

5a. If married, widowad, or divorcad HUSBAND of (or) WIFE of George V. Midkiff

6. DATE OF BIRTH (month, day, and year) Oct. 12 1888

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
57	0	9	

OCCUPATION

8. Trade, profassion, or particular kind of work dona, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was dona, as SILK MILL, SAW MILL, BANK, atc. Own Home

10. Data deceased last worked at this occupation (month and yaar)

11. Total tima (years) spant in this occupation

12. BIRTHPLACE (city or town) (State or country) West Virginia

FATHER

13. NAME Floyd A. Smith

14. BIRTHPLACE (city or town) (State or country) W. Va.

MOTHER

15. MAIDEN NAME Emma Zetta

16. BIRTHPLACE (city or town) (State or country) W. Va.

17. INFORMANT Vera Kennedy

(Address) Washington D. C.

18. BURIAL, CREMATION, OR REMOVAL Burial

Place Lincoln Co. W. Va. Date Oct. 25, 1945

19. UNDERTAKER Wastler Funeral Home

(Address) 901 E. Capitol St. Wash. D.C.

20. FILED 10/22, 1945 Amanda Downey Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH October (Month) 22 (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attendad deceased from August 30, 1945, to October 22, 1945

I last saw h...er alive on October 21, 1945 Death is said to have occurred on the date stated above, at 11 a.m.

The PRINCIPAL CAUSE OF DEATH and relatad causas of importance ware as follows:

	Date of onset
Hypertensive cardiac disease	Unknown
Congestive failure	

Other Contributory Causes of importance:

Congestive failure

Name of operation none Date of

What test confirmad diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did Injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Natura of Injury

24. Was disaasa or injury in any way related to occupation of decaased? no

If so, specify

(Signad) Henry G. Handley M. D.

(Address) 1252 - 6th St., S. W.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 hrs

Hospital, Institution, or street address where death occurred:

Eugene Leland Memorial Hospital

How long in hospital or institution? 4 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 123 Carroll Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war: -

3. (a) FULL NAME: Miller, Mrs Jemima

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Widowed

6.(b) Name of husband or wife: John Miller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 15 1864

8. AGE: Years: 81 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Scotland (Town, county, and state)

10. Usual occupation: Nurse

11. Industry or business: Odd Jobs

FATHER 12. Name: Campbell

FATHER 13. Birthplace: Scotland

MOTHER 14. Maiden name: Elizabeth

MOTHER 15. Birthplace: Scotland

18. Informant: Hospital Records & guess

Address: by daughter on admission

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 31, 1945 (month) (day) (year)

Cemetery or crematory: Ben Wash. Memorial Cemetery

Location: Riggs Rd & Eastern Ave, Md.

18. Funeral director: Arthur Adlers

Address: 354 Carroll St. N.W., Takoma Park D.C.

19. Oct 28 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 28 1945, at 2:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/21/33, to 10/28/45 and that I last saw h... alive on 10/28/45

	DURATION
Immediate cause of death: Cerebral Hemorrhage	16 hrs
Due to: Hypertension &	
Due to: Chronic Arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Howard V Snorf MD M. D. or other

Address: 38 Carroll Ave Takoma Park Md Date signed 10/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-c)

CERTIFICATE OF DEATH

10293 245

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Prince Georges

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4½ years

Hospital, institution, or street address where death occurred:

405 Circle Ave

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. Circle Ave

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME June Emma Mitchler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Albert Ernest Mitchler 6.(c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) May 30, 1920

8. AGE:

Years	Months	Days	If less than one day
25	4	2	..... hrs. ..... min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

MOTHER FATHER

12. Name Edward Smith

13. Birthplace Virginia

MOTHER

14. Maiden name Dorothy Clinton

15. Birthplace Washington, D.C.

16. Informant Mary Lo Poirier

Address 824 Eighth St. N.E., Washington D.C.

17. Cremation Date thereof Oct 3 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hyattsville Funeral Home

Location Hyattsville, Md.

18. Funeral director F. Gaasch's Son

Address Hyattsville, Md.

19. Oct 3 1945 James Seery

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1945, at 8:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage and Shock	
Due to Gun shot wound of head	
Due to	
Other conditions About 5 months pregnant (include pregnancy within 3 months of death)	

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 10-2-45

Where did injury occur? Takoma Park (City or town) P.G. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Shot self with revolver Injured at work? No

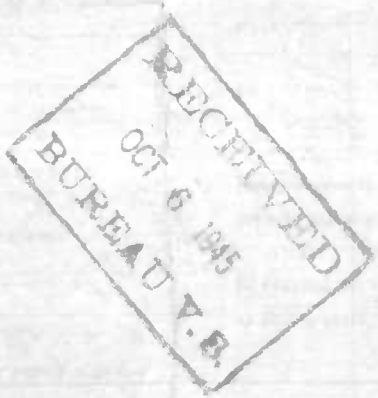
23. SIGNATURE Deputy Medical Examiner M.D. or other

Address Hyattsville Md. Date signed 10-2-45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
OCT 6 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15a)

CERTIFICATE OF DEATH

10294

Reg. Diat. No. 231

1. PLACE OF DEATH:
County PRINCE GEORGES
City or town ARDMORE
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 MONTHS
Hospital, institution, or street address where death occurred:
EDNA MARINE NURSING HOME.
How long in hospital or institution? 4 MONTHS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State PENNA. County FRANKLIN
City or town CHAMBERSBURG
(If outside city or town limits, write RURAL and give nearest town)
Street No. #1 FOLTZ ALE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles HERBERT OCKER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JUNE 24, 1944

8. AGE: Years	Months	Days	If less than one day
1	3	17	hrs. ..... min.

9. Birthplace MARTINSBURG, W. VA.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name JOHN R. OCKER
13. Birthplace CHAMBERSBURG, PA.

MOTHER
14. Maiden name FRANCES RUNKLES
15. Birthplace MARTINSBURG, W.VA.

16. Informant JOHN R. OCKER
Address 1215 EUTAW PL. BALTO, MD.

17. transportation (Burial, cremation, or removal. Which?) Date thereof OCT 11. 1945 (month) (day) (year)

Cemetery or crematory
Location CHAMBERSBURG, PENNA.

18. Funeral director F. Gaschi Sons
Address HYATTSVILLE, MD.

19. 10/11 (Date rec'd by registrar) 19 45 Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 19 45, at 12-15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 45, to Oct 10 19 45
and that I last saw h. / M. alive on Oct 1 19 45

	DURATION
Immediate cause of death	
Hydrocephalus	1 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John J. Maloney M.D. M.D. or other
Address Baltimore, Md Date signed 10-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10295

Reg. Dist. No. 214

WITHIN CORPORATE LIMITS

1. PLACE OF DEATH:
County Pr Prince Georges
City or town Laurel (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred: 307 Prince Georges Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Burtonsville (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war no

3.(a) FULL NAME CLARA S. PARSLEY Parsley

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband XXX Arthir R. Parsley
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) June 6th. 1874

8. AGE: Years	Months	Days	If less than one day
71	4	16	..... hrs. ..... min.

9. Birthplace Prince Georges Co. Md. (Town, county, and state)
10. Usual occupation Retired
11. Industry or business

FATHER
12. Name John Wm. Lusby
13. Birthplace Maryland

MOTHER
14. Maiden name Mary Rachel Parker
15. Birthplace Maryland

16. Informant Arthur R. Parsley
Address Burtonsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/24/45 (month) (day) (year)
Cemetery or crematory Burtonsville Union
Location Burtonsville, Montg. Co. Md.
18. Funeral director Warren Humphreys
Address 8434 Ga. Ave. Silver Spring. Md.

19. Oct 23 19 45 Josephine M Schaffe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 19 45 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 17 19 45 to Oct 22 19 45
and that I last saw h.. alive on Oct 22 19 45

Immediate cause of death	DURATION
Bronchopneumonia	3 days
Due to Acute Tuberculosis	5 days
Due to Myelonephritis	
Other conditions Hypertension	10 yrs
Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J M Warren M.D. M. D. or other
Address Laurel Md. Date signed 10/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95C)

CERTIFICATE OF DEATH

Reg. Dist. No. 2 3 9

1. PLACE OF DEATH
County Prince George County
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 weeks
Hospital, Institution, or street address where death occurred:
Davis Home
How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Rising Sun
(If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
David Ross Parsons

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 21, 1945

8. AGE:

Years	Months	Days	If less than one day
	9	10	hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name William John Parsons
13. Birthplace Muskegon, Michigan

MOTHER
14. Maiden name Lorraine Johnson
15. Birthplace Rising Sun, Md.

16. Informant Lorraine J. Parsons
Address Rising Sun, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 8 1945 (month) (day) (year)
Cemetery or crematory Brookview
Location Rising Sun Md.

18. Funeral director J. E. Tyson
Address Rising Sun Md.

19. November 2 1945 (Date rec'd by registrar) Cora E. Wachter Deputy. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1945 at 9:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 10, 1945 to Oct. 31 1945
and that I last saw h. alive on October 30 1945

	DURATION
Immediate cause of death Central	
atrophy	
acute fulminating Gallstone	
Due to Dehydration	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B P Warren M. D. or other
Address Laurel Md Date signed 11-1-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (07)

CERTIFICATE OF DEATH

11297
230

Reg. Dist. No.

1. PLACE OF DEATH:

County: Prince Georges

City or town: Greenbelt

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

Greenbelt Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Greenbelt

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Greenbelt Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henry William Parsons

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Vera I Parsons

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Oct 1, 1868

8. AGE:

Years	Months	Days	If less than one day
77	0	8	...hrs. ...min.

8. Birthplace: Berlin Heights, Ohio (Town, county, and state)

10. Usual occupation: Retired Banker

11. Industry or business: Banking

FATHER

12. Name: Henry Parsons

13. Birthplace: Ohio

MOTHER

14. Maiden name: Laverne Neeman

15. Birthplace: Ohio

16. Informant: Marion P Robinson

Address: Greenbelt Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Oct 10/945 (month) (day) (year)

Cemetery or crematory: Lee's Crematory

Location: Wash D.C

18. Funeral director: Wm. Lee's Sons Co

Address: 300-4-st N.W. D.C

19. 10/9 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 9 1945, at 9:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h...alive on ...19...

Immediate cause of death	DURATION
Exhaustion	
Due to: Toxemia	
Due to: Bronchopneumonia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Deputy medical Examiner

23. SIGNATURE: James J. Bonn M. D. or other

Address: Forestville Md Date signed: 10-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

10298

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 242

1. PLACE OF DEATH:
County: Prince George
City or town: Capitol Hgts
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Geo
City or town: Capitol Hgts
(If outside city or town limits, write RURAL and give nearest town)
Street No. 607 49th Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: MARGARET VIRGINIA PAYNE

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: Walter D. Payne
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 26th 1858

8. AGE: Years	Months	Days	If less than one day
86			..... hrs. ..... min.

9. Birthplace: Washington DC
(Town, county, and state)
10. Usual occupation: none
11. Industry or business: none

FATHER
12. Name: William H. Jett
13. Birthplace: Va

MOTHER
14. Maiden name: Mary Brewer
15. Birthplace: Va

16. Informant: Mr Leroy Payne
Address: 607 49th ave Capt. Hgts.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-24-45 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Bladensburg Md
18. Funeral director: W. W. Chambers Co
Address: 517 11th St S.E.

19. 10/22/45 (Date rec'd by registrar) Carrie F. Campbell, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 19 45 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 19 42 to Oct 22 19 45 and that I last saw h[illegible] alive on Oct. 21 1945 19

Immediate cause of death	DURATION
Cardiovascular Disease	5 yrs
Due to arteriosclerosis	
Due to	
Other conditions: Breast Cancer removed	2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: George I. Eppard M. D. or other
Address: 4101 Minn-an Rd. Date signed 10, 22, 45
Washington D.C.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (134)

CERTIFICATE OF DEATH

1029)

★ Reg. Dist. No. 243

1. PLACE OF DEATH:
County: Prince George's
City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mos., 8 days
Hospital, institution, or street address where death occurred: Glenn Dale Sanatorium
How long in hospital or institution? 2 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1433 Meridian Pl., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: THOMAS B. POTTS

3.(b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: -
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 16, 1868

8. AGE:

Years	Months	Days	If less than one day
77	-	2	hrs. min.

9. Birthplace: King George, Virginia (Town, county, and state)
10. Usual occupation: Retired Gov't. Worker
11. Industry or business

FATHER
12. Name: Hezkiah Potts
13. Birthplace: Virginia

MOTHER
14. Maiden name: Anne Ball
15. Birthplace: Virginia

16. Informant: Decedent
Address

17. (Burial, cremation, or removal. Which?) Removal to Wash. D.C. Date thereof: Oct. 18 45 (month) (day) (year)
Cemetery or crematory: Removal to Wash. Polick Cem.
Location: Easton, Md.

18. Funeral director: W. W. Chambers Co. (Rec'd)
Address: 3072 M. St. N.W. Wash. D.C.

19. Oct. 18, 1945 Rowland S. Phillips
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 18 1945 at 4.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 10 1945 to Oct. 18 1945 and that I last saw h.. alive on Oct. 17 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	11 mo.
Due to	
Due to	
Other conditions: Acute cystitis,	2 mo
arteriosclerosis.	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Bilateral pulmonary tuberculosis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Pincare M.D.
M. D. or other
Address: Glenn Dale, Md. Date signed: 10/18/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

16300

245

Reg. Dist. No.

1. PLACE OF DEATH:
County: Prince Georges County
City or town: Hyattsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pro Geo Co
City or town: Hyattsville Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4110 Gallatin st
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Smith White Purdum

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Laura Dolan Purdum
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 12, 1876

8. AGE: Years	Months	Days	If less than one day
68 years			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Assistant Postmaster
11. Industry or business: U. S. Government

FATHER
12. Name: Thomas L. Purdum
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emma Lewis
15. Birthplace: Maryland

16. Informant: Laura Dolan Purdum
Address: Hyattsville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 6, 1945 (month) (day) (year)
Cemetery or crematory: Fort Lincoln Cemetery
Location: Colmar Manor Maryland
18. Funeral director: F. Gasch's Sons
Address: Hyattsville Maryland

19. Oct 6 1945 (Date rec'd by registrar) James Leary Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 4, 1945 at 3;10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1945 to Oct 4 1945 and that I last saw him alive on Oct 3 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Hyattsville Md Date signed 10-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

CERTIFICATE OF DEATH

1631

★ Reg. Dist. No. 243

1. PLACE OF DEATH:

County: Prince Georges

City or town: Glenn Dale, Md. - RURAL
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months -- 3 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 10 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2422- 2d Street, N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: RAINEY, BETTY, L

3. (b) Social Security Number: 579-20-4123

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 19, 1925

8. AGE:

Years	Months	Days	If less than one day
20	3	19	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: -

FATHER
12. Name: Robert L. Rainey
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Dorothy Burch
15. Birthplace: Millwood, Virginia

16. Informant: decedent
Address

17. Removal to (Burial, cremation, or removal. Which?) Date thereof: 10 - 9 - 45 (month) (day) (year)

Cemetery or crematory:

Location: Washington

18. Funeral director: H. Gr. Chamberlain & Sons

Address: 1400 Chapin St., N.W. Wash D.C

19. Oct 8 (Date rec'd by registrar) 19 45 Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 8, 19 45, at 145 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/5 19 44 to 10/8 19 45 and that I last saw h.. alive on Oct. 8, 19 45

Immediate cause of death	DURATION
Tuberculosis pulmonary	13 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale, Md. Date signed: 10/8/45

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10302

CERTIFICATE OF DEATH

Reg. Diat. No. 243

1. PLACE OF DEATH:

County: Prince George's

City or town: (rural) Glenn Dale, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, institution, or street address where death occurred:
Glenn Dale Sanatorium

How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 127 - C. Street N. E.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: REED, RUTH

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Louis Reed

6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): March 3, 1902

8. AGE: Years	Months	Days	If less than one day
43	7	13	...hrs. ...min.

9. Birthplace: Norwich, New York
(Town, county, and state)

10. Usual occupation: School Teacher

11. Industry or business:

FATHER
12. Name: Wm. A. Baldwin
13. Birthplace: Guilford, New York

MOTHER
14. Maiden name: Grace Wylie
15. Birthplace: Coventry, New York

16. Informant: Decedent
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 16, 1945 (month) (day) (year)

Cemetery or crematory: Beulah Cemetery

Location: Elizabeth ... W. Va.

18. Funeral director: Wm. Lewis Sons Co

Address: 300-4 st. N.E. Wash. D.C.

19. Oct. 16, 1945 (Date rec'd by registrar) Rowland S. Phillips Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 16 1945 at 5:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 10/7 1945 to 10/16 1945 and that I last saw h... alive on 10/16/45 1945

Immediate cause of death	DURATION
(a) Tuberculosis pulmonary	16 years
Due to (b)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (whore?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Daniel Leo Finucane M.D.
M. D. or other

Address: Glenn Dale Md. Date signed 10/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

10363

CERTIFICATE OF DEATH

Reg. Diat. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Prince Georges

City or town: Mt. Hyattsville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Mt. Hyattsville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Riggs Road Extended

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ethel Helena Roberts

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Roberts

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 1 1884

8. AGE: Years 61 Months 9 Days 24 If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name: Wm. M. Fowler

FATHER 13. Birthplace: England

MOTHER 14. Maiden name: Anna A. Clements

MOTHER 15. Birthplace: Maryland

16. Informant: Mrs Lillie M. Burgess

Address: Riggs Rd. Extended

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 29 1945 (month) (day) (year)

Cemetery or crematory: St. Marys

Location: Rockville, Maryland

18. Funeral director: Warner E. Pumphrey

Address: 8434 Ga. Ave. Silver Spring, Md.

19. Oct. 27" 1945 James Severe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 25 19 45 at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-2-45 19..... to 10-25 19 45

and that I last saw h... on 10-24-45 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	3 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John P. Clum M.D.

M. D. or other

Address: Hyattsville Date signed 10-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

10304

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Pro Georges County
City or town: Cottage City Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Pro Geo County
City or town: Cottage City Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3719 38th avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas H. Rollings

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Emily Rollings
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Feb 28, 1875

8. AGE: Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace: New York
(Town, county, and state)
10. Usual occupation: Painter
11. Industry or business: U. S. Government

FATHER
12. Name: Samuel Rollings
13. Birthplace: Unknown

MOTHER
14. Maiden name: Sarah Brock
15. Birthplace: New York

16. Informant: Emily Rollings
Address: Cottage City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 4, 1945 (month) (day) (year)
Cemetery or crematory: Arlington Cemetery
Location: Arlington Virginia

18. Funeral director: F Gasch's Sons
Address: Hyattsville Maryland.

19. 10/2 1945 (Date rec'd by registrar) Amanda Downey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 1, 1945 19... at 1.23A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 30 19 45 to Oct 1 19 45
and that I last saw him alive on Oct 1, 19 45

Immediate cause of death	DURATION
Toxic myocarditis	1 day
Due to: Cerebral apoplexy	2 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank R. Shea M.D. M. D. or other
Address: 4100-22nd St. NE Date signed: Oct 2, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

16305

Reg. Dist. No. 242

1. PLACE OF DEATH:

County: Prince George

City or town: 6501 Buchanan St Maryland Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Evelyn Marie Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 24, 1915

8. AGE: Years	Months	Days	If less than one day
30	3		hrs. min.

9. Birthplace: Chicago, Ill.
(Town, county, and state)

10. Usual occupation:

11. Industry or business: National Bureau Standard

FATHER
12. Name: John Smith
13. Birthplace: New York

MOTHER
14. Maiden name: Nellie Coons
15. Birthplace: Penna.

16. Informant: Miss Joan Quill
Address: 6501 Buchanan St. Maryland Park Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 2, 1945 (month) (day) (year)

Cemetery or crematory: Forrest Home,
Location: Chicago, Ill.

18. Funeral director: Francis J. Collins
Address: 3821-14st N.W. Wash. D.C.

19. Oct. 30 1945 (Date rec'd by registrar) Carrie F. Campbell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 20 1945, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 20 1945 to Oct 20 1945 and that I last saw h[illegible] alive on October 20 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3-7 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: William Brannin M. D.

Address: 614 Central Ave Capitol Heights Md Date signed: 10/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10/30/45

Coroner Boyd notified & permission to sign certificate given.

W Brannin, MD

Evidence for the change of age is shown on

10306

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186a)

CERTIFICATE OF DEATH

C-99 NOV 2 1945

Reg. Dist. No. 245

1. PLACE OF DEATH:

County: Prince Georges

City or town: Riverdale Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months 12 days

Hospital, institution or street address where death occurred:

Leland Memorial Hospital

How long in hospital or institution? 4 mos. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4014 Ingraham St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Mary Rebecca Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife: Maurice Smith

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 4, 1872

8. AGE: Years	Months	Days	If less than one day
73	11/12	22	..... hrs. ..... min.

9. Birthplace: ? Ohio

(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER 12. Name: Benjamin Frederick Miller

13. Birthplace: ? Va.

MOTHER 14. Maiden name: Amanda Elizabeth Lowdy

15. Birthplace: ? Va.

16. Informant: Leland Memorial Hospital Records

Address: Riverdale, Md.

17. (Burial, cremation, or removal. Which?) Date thereof Oct 26-45 (month) (day) (year)

Cemetery or crematory: Removal

Location: Vienna Va.

18. Funeral director: Mary E King

Address: Vienna Va.

19. Oct 26, 1945 (Date rec'd by registrar) James Severy (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 26, 1945, at 11 50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14, 1945, to Oct. 26, 1945 and that I last saw h... alive on Oct 24 1945

Immediate cause of death	DURATION
Fractured Hip	4 mo. 12 days
Due to	
Due to	
Other conditions: Hypostatic pneumonia - sclerosis and senility	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: June 13, 1945

Accident, suicide, or homicide: accident Date of

Where did injury occur? Hyattsville (City or town) Md. (County) (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Fall. Injured at work? No.

23. SIGNATURE: L W Mellin M.D.

M. D. or other

Address: Riverdale, Md. Date signed: 10-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10307

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cottage City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, institution, or street address where death occurred: 3702 40th Pl.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: Cottage City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3702 40th Pl. Cottage City
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: William F. Smith

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary A.
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 3 1863

8. AGE: Years	Months	Days	If less than one day
82	3	17	...hrs. ...min.

9. Birthplace: D. C. (Town, county, and state)
10. Usual occupation: Engineer
11. Industry or business: —

FATHER
12. Name: Wm. P. Smith
13. Birthplace: England

MOTHER
14. Maiden name: Mary E. Goodrich
15. Birthplace: D. C.

16. Informant: Mrs. Mary E. Simpson
Address: 3702 40th Pl.
17. removal (Burial, cremation, or removal. Which?) Date thereof 10/24/45 (month) (day) (year)
Cemetery or crematory:
Location:
18. Funeral director: W. W. Chamberlin Co.
Address: 3072 M. St. N. W.
19. 10/20 1945 Amanda Downey (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/20 1945, at 5:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/10 1945, to 10/20 1945 and that I last saw h. alive on 10/20 1945

Immediate cause of death	DURATION
Coronary Occlusion	
Due to Arteriosclerotic Heart & Kidney disease	
Due to Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: George Dragaquen D (M. D. or other)
Address: 3717 - 38th Ave. Date signed: 10/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

10398

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

Prince George

CERTIFICATE OF DEATH

Reg. Dist. No. 2-2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH: 803- 59th Ave NE

County ...

City or town ~~Fort Washington~~ Wash DC (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 mo

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State N. C. County Mecklenburgh

City or town Carlotte (If outside city or town limits, write RURAL and give nearest town)

Street No. 1121- Brown St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Hettie Henrietta Sullivan

3. (b) Social Security Number

4. Sex: Femal

5. Color or race: Col

6.(a) Single, married, widowed, or divorced: (widowed circled)

6.(b) Name of husband or wife: None

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) 7-28-1876

8. AGE: Years 69 Months 2 Days 15 If less than one day ... hrs. ... min.

9. Birthplace ~~Laurens~~ Laurens, S.C. (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Alberta S. Daniels

Address 803- 59th Ave NE.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 18, 1945 (month) (day) (year)

Cemetery or crematory Lincoln Memorial Cem.

Location Suitland, Md.

18. Funeral director Frazier Funeral Home

Address 389 R.I. Ave NE.

19 Octobe 12 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1945, at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16 1945, to Oct 12 1945 and that I last saw her alive on Oct 12 1945

Immediate cause of death	DURATION
Cerebral Haemorrhage	
Due to Hypertension	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE H. E. Booker M. D. or other

Address 423- ... Date signed 10-13-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53-e)

CERTIFICATE OF DEATH

Reg. Dist. No. 230

1. PLACE OF DEATH: County: Prince George; City or town: Greenbelt, Md. (If outside city or town limits, write RURAL and give nearest town); How long in above place of death? 10 months, 28 days; Hospital, institution, or street address where death occurred: 28-A Crescent Rd.; How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State: Maryland; County: Prince George; City or town: Greenbelt, (If outside city or town limits, write RURAL and give nearest town); Street No.: 28-A Crescent Road (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: VALENTINE V. TCHIKOFF

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Mary Tchikoff

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): October 30, 1883

8. AGE: Years	Months	Days	If less than one day
61	11	7	hrs. min.

9. Birthplace: VLADIKAVKA'S, RUSSIA (Town, county, and state)

10. Usual occupation: Civil engineer

11. Industry or business: Town of Greenbelt

FATHER — 12. Name: Basil I. Tchikoff; 13. Birthplace: Russia

MOTHER — 14. Maiden name: Anna Schmuhyarova; 15. Birthplace: Russia

18. Informant: Mrs. Mary Tchikoff, Wife; Address: 28-A Crescent Rd, Greenbelt, Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Oct. 9-1945 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Bladensburg-Baltimore Blvd. & D.C. Line

18. Funeral director: Wm. J. Malloy

Address: 3200 Bladensburg Ave., Mt. Rainier, Md.

19. Oct. 9 1945 (Date rec'd by registrar) James Sevey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 7, 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27, 1945, to October 7, 1945 and that I last saw him alive on October 6, 1945

Immediate cause of death	DURATION
Metastatic carcinoma to brain	6 months
Due to: Primary carcinoma site not known	2
Due to:	
Other conditions: Cirrhosis, Benign prostatic hypertrophy	6 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hans Wodak, M.D. (M. D. or other)

Address: 30-D Bridge Rd, Greenbelt Date signed: 10-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

10310

★ Reg. Dist. No. 245

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges
City or town Mt. Ranier Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince Georges
City or town Mt. Ranier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2800 Upshur St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Bessie F. Thiele

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

B.(b) Name of husband or wife Harold J. Thiele
B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 28 1898

8. AGE: Years	Months	Days	If less than one day
47			....hrs. ....min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual occupation Examiner
11. Industry or business U.S. Gov.

FATHER
12. Name Evan J. Fuge
13. Birthplace unkown

MOTHER
14. Maiden name Edith Brokenshire
15. Birthplace Unkown

16. Informant Harold J. Thiele
Address 2800 Upshur St. Mt. Ranier

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 15 1945 (month) (day) (year)
Cemetery or crematory Cedar Hill Cem.
Location Md.

18. Funeral director J. Wm Lees Sons
Address 300-4th St NE

19. 10/11 1945 Amanda Dacey
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1945, at 4:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-3 1943, to 10-11 1945 and that I last saw h[illegible] alive on 10-10 1945

Immediate cause of death	DURATION
Carcinoma of Right Breast with metas	
metastasis to Chest & Spinal Colm	2½ Yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Scirrous Carcinoma of right breast Date of op. 9-22-43
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. B. Mayer M.D. M. D. or other
Address Mt. Ranier Md Date signed 10-11-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

16311

CERTIFICATE OF DEATH

Reg. Dist. No. 242

1. PLACE OF DEATH:

County Prince Georges

City or town Forestville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 years

Hospital, institution, or street address where death occurred:

8110 Marlboro Pike Rt 2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince Georges

City or town Forestville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8110 Marlboro Pike Rt 2

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Mason Tippett

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Tippett

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Feb 8, 1874

8. AGE:

Years	Months	Days	If less than one day
71	8	14	hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER

12. Name William Tippett

13. Birthplace Maryland

MOTHER

14. Maiden name Margaret

15. Birthplace Maryland

16. Informant Mrs Carrie Buckler

Address 1532-61st Ave, Spaulding Hts Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 25 1945 (month) (day) (year)

Cemetery or crematory Mt Calvery

Location Forestville Md

18. Funeral director Ritchie Brothers

Address Upper Marlboro Md

19. Oct 31 1945 (Date rec'd by registrar) Thos D Griffith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1945, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 to Oct 22 1945 and that I last saw h. alive on Oct 21 1945

Immediate cause of death	DURATION
acute Congestive heart failure	
Due to Cardiovascular renal disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James D Bond M. D. or other

Address Forestville Md Date signed 10-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

10312

CERTIFICATE OF DEATH

Reg. Dist. No. 231

1. PLACE OF DEATH:
County: Prince George
City or town: Cheverly, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 days
Hospital, Institution, or street address where death occurred:
Prince George's General Hospital
How long in hospital or institution? 25 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Prince George
City or town: Rutland.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11 Glen St. Rutland
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Van Arsdale Mr. Ernest

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Van Arsdale Mrs. Jennie
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Oct. 1, 1880

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
65	~~11~~	30		

9. Birthplace: Michigan (Town, county, and state)
10. Usual occupation: Fire inspector.
11. Industry or business:

FATHER
12. Name: John Van Arsdale
13. Birthplace: Osceola Co. Hall. Mich

MOTHER
14. Maiden name: Mary Fisher
15. Birthplace: Mich

16. Informant: Norman V. Van Arsdale.
Address: 11 Glen St Rutland, Md.

17. Howell Michigan Burial (Burial, cremation, or removal. Which?) Date thereof: 11 (month) 1 (day) 1945 (year)
Cemetery or crematory:
Location: Howell Michigan
18. Funeral director: C. J. Saffell
Address: 475 H-St N.W. Washington 6

19. 10/31 1945 (Date rec'd by registrar) Amanda Deane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-31 1945, at 6:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945, to Oct 31 1945, and that I last saw h~~im~~ alive on Oct 31, 1945

Immediate cause of death	DURATION
Acute Congestive Heart failure.	
Arterio-sclero-Renal- disease	
Due to Diabetes. -	
Diabetic gangrene	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M Pringle M. D.
M. D. or other
Address: Prince Geo Gen Hosp Cheverly Date signed: 10-31-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

10313

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

Reg. Dist. No. 243

1. PLACE OF DEATH:
County Prince George's Co.
City or town Mitchellville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Prince Geo. Co
City or town Mitchellville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Near Woodmore
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Anne Merle Walker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26 - 198

8. AGE: Years	Months	Days	If less than one day
27	10	26	hrs. min.

9. Birthplace Mitchellville Prince Geo Co Md
(Town, county, and state)

10. Usual occupation
11. Industry or business

FATHER
12. Name Edw. S. Walker
13. Birthplace Washington D.C.

MOTHER
14. Maiden name Anne Ardella Harman
15. Birthplace A.A. Co. Md

16. Informant W. Desmond Walker
Address Mitchellville. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 22 1945 (month) (day) (year)
Cemetery or crematory Mt Oak
Location Woodmore Md
18. Funeral director Thos Gaschis Sons
Address Bladensburg Md
19. Oct 21 19 45 (Date rec'd by registrar) Lottie H. Peach Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 19 45, at 9:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 42 to Oct. 20 19 45 and that I last saw h.. alive on Oct 20 19 45

	DURATION
Immediate cause of death: Epilepsy	22 yrs.
Due to	
Due to	
Other conditions: Obesity	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James E. Hasser M. D. or other
Address Upper Marlboro, Md Date signed 10-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

111314

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33a)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 245

1. PLACE OF DEATH:
County Prince Georges Co
City or town Hyattsville Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days.
Hospital, institution, or street address where death occurred:
4030 Hamilton Street.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Pennsylvania County Blair County.
City or town Altoona
(If outside city or town limits, write RURAL and give nearest town)
Street No. 412 Crawford Ave
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Mr Roy Leslie Wertz.

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married.

6.(b) Name of husband or wife Minnie Mae Sickles (deceased 1st wife) Priscella Ann Walters Wertz 6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) May 5, 1882.

8. AGE: Years	Months	Days	If less than one day
73.	5	10	....hrs. ....min.

9. Birthplace Williamsburg, Blair Co. Penna. (Town, county, and state)
10. Usual occupation machinist (retired)
11. Industry or business Pa Railroad in Altoona Pa.

FATHER
12. Name Jacob B Wertz
13. Birthplace Williamsburg, Blair Co. Pa.

MOTHER
14. Maiden name Sarah Wagner
15. Birthplace Spruce Creek, Blair Co. Pa.

16. Informant Dau.
Address 4030 Hamilton St Hyattsville Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Oct 19th 1945 (month) (day) (year)
Cemetery or crematory Grandi View
Location Tyrone Penna.
18. Funeral director Geo. W Wise Co.
Address 2900 M St N.W. Washington D.C.

19. Oct 16 1945 James Devery
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1945, at 6 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 4 1945, to Oct 16 1945
and that I last saw him alive on Oct 14 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage with Left hemiplegia	12 days
Due to Hypertension	12 yrs
Due to General arteriosclerosis	12 yrs
Other conditions Prostatic hypertrophy	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op. ....
Autopsy results ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE L W Mellon MD M. D. or other
Address Riverdale, Md. Date signed 10-16-45

M

I

7

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for the change of date of birth is shown on Film G 99 11-14-45

10315

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Prince Georges [redacted]
City or town Cheverly
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 1/2 hours
Hospital, Institution, or street address where death occurred:
Prince Georges General Hospital
How long in hospital or institution? 3 1/2 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George County
City or town Mt. Rainier
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4042 - 34th St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mrs Annie Laurie Wilson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Harvie Edgar Wilson
6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Dec. 20-1884/1887

8. AGE: Years	Months	Days	If less than one day
57	10	0	hrs. min.

9. Birthplace Richmond Virginia
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home
FATHER 12. Name William Brown
13. Birthplace ?, Virginia
MOTHER 14. Maiden name ?
15. Birthplace
16. Informant Mr. Harvie E. Wilson
Address 4042 - 34th St. Mt. Rainier, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 26-1945 (month) (day) (year)
Cemetery or crematory Washington Memorial Park
Location Riggs Road Md. Prince George County
18. Funeral director Wm J. Malloy
Address 3200 - R. I. Ave. Mt. Rainier Md.
19. Oct 25 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 19 45 at 7:34 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Acute Congestive heart failure	
Due to myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work? .....

23. SIGNATURE Deputy Medical Examiner
M. D. or other
Address Forestville Md. Date signed 10-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

10316

CERTIFICATE OF DEATH

Reg. Dist. No. 232

1. PLACE OF DEATH:
County: Prince George's
City or town: Upper Marlboro Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Upper Marlboro, Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Anne Wyvill

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: Anthony J. Wyvill
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 29 1866

8. AGE:

Years	Months	Days	If less than one day
79	0	24	hrs. min.

9. Birthplace: Upper Marlboro, Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: home

FATHER
12. Name: Nicholas O. Ridgely
13. Birthplace: Prince George Co Md

MOTHER
14. Maiden name: Anne Elizabeth Lomax
15. Birthplace: Prince George's County

16. Informant: Mabel Wyvill
Address: Upper Marlboro, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 27 45 (month) (day) (year)
Cemetery or crematory: Mt Carmel
Location: Upper Marlboro Md
18. Funeral director: Pitcher Brothers
Address: Upper Marlboro Md

19. Oct 26 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION P.

20. DATE OF DEATH: October 24 1945 at 12:35 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1943 to Oct 24 1945 and that I last saw her alive on Oct. 24 1945

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to: Arteriosclerosis	10 yrs
Due to: Nephritis	5 yrs
Other conditions: none	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.: none
Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James L. Fussell M. D. or other
Address: Upper Marlboro, Md Date signed 10-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (79-2)

CERTIFICATE OF DEATH

10317245 ★ Reg. Dist. No.

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Prince George
City or town: University Park,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George
City or town: University Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4327 Van Buren St.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #1.

3. (a) FULL NAME: ADOLPH JOSEPH YANKA

3. (b) Social Security Number: 578 - 07 - 7844

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Cecilia M. Yanka
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): April 6, 1894

8. AGE: Years	Months	Days	If less than one day
51			hrs. min.

9. Birthplace: New York City (Town, county, and state)
10. Usual occupation: Mfg. Representive
11. Industry or business: Electric Control Equipment
FATHER 12. Name: Joseph Yanka
13. Birthplace: Switzland
MOTHER 14. Maiden name: Marie Traffur
15. Birthplace: Switzland
16. Informant: Mrs Cecilia M. Yanka
Address: 4327 Van Buren St.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 4 1945 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: Bladensburg, Md. At D.C. Line
18. Funeral director: J. William Lee's Sons Co.
Address: 300 - 4th, St. N.E. Washington, D.C.
19. Oct 3 1945 (Date rec'd by registrar) James Seery Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 1 1945 at 10:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-27 1945, to 10-1 1945
and that I last saw him alive on 9-26 1945

	DURATION
Immediate cause of death: Coronary Occlusion	1 hour
Due to: Hypertension, Arteriosclerotic Heart Disease	2 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D.
M. D. or other
Address: Mt. Rainier Md. Date signed: 10-2-45

Dr Meyer. UX1154